Arizona Department of Health Services Office for Children with Special Health Care Needs Children's Rehabilitative Services Administration	**Effective Date: 06/04/2007**
SUBJECT: QUALITY MANAGEMENT	SECTION: QM 1.5

SUBTITLE: CRSA QUALITY OF CARE PROCESS

POLICY:

It is the policy of Children's Rehabilitative Services Administration (CRSA) to assure timely, responsive, and effective processes to identify and correct Quality of Care concerns which may arise within the delivery system.

STANDARD:

1) Children's Rehabilitative Services Administration (CRSA), Division of Quality Management (QM) attempts to resolve all grievances as expeditiously as possible. Most grievances should be resolved within 10 business days of receipt, but in no case longer than 90 days.
2) The QM Coordinators will have the necessary clinical, administrative, and quality assurance knowledge and expertise to facilitate CRSA's Quality Process.
3) CRSA will ensure the confidentiality of all member information. The Quality of Care Process is a protected process as provided by Arizona Revised Statutes: A.R.S. §36-441, A.R.S. §36-445, A.R.S. §36-2401 through 2404, A.R.S. §36-2917, and 42 CFR 434.34. Quality of Care concerns will be addressed with an Executive Session of the CRSA Quality Management Committee (QMC). Additionally, confidentiality will be attested by each member of the QMC and Peer Review Committee.
4) CRSA will assure member health records are made available and accessible to authorized staff and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse and grievances.

DEFINITIONS:

1) Action: Denial or limited authorization of a requested service, including the type or level of service; Reduction, suspension, or termination of a previously authorized service; Denial, in whole or in part, of payment for a service; Failure to provide services in a timely manner; Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of

grievances; or Denial of a rural CRS recipient's request to obtain services outside CRSA or its subcontractors' network under 42 CFR 438.52(b)(2)(ii), when CRSA or its subcontractors is the only Contractor in the rural area.

2) Assess or Evaluate: The process used to examine and determine the level of quality or the progress towards improvement of quality and/or performance related to CRS Regional Contractor service delivery systems.

3) Corrective Action Plan (CAP): A written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the CRS Regional Contractors, to enhance QM/PI activities and the outcomes of the activities, or to resolve a deficiency.

4) Grievance: An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to:
   a) The quality of care or services provided; and
   b) Aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

5) Level of Severity: The designation of a quality of care concern as to degree of life threat, disability or other adverse outcome.

6) Non-Quality of Care Concern: A grievance that has no possibility of impacting the member's health care status.

7) Quality of Care Concern: If there is any possibility that the grievance/ concern identified could impact the member's health care status in any way, it must be treated as a quality of care concern.

8) Quality of Care Database: The database where all CRSA grievances and potential quality of care review and referrals are entered for monitoring, tracking and trending purposes.

9) Substantiated: Defined as an allegation of abuse or complaint, which was verified or proven to have happened based upon available evidence. Substantiated allegations of abuse or complaints require a corrective action plan (CAP).

10) Unsubstantiated: Defined as an allegation or complaint, which was based on evidence and verified to not have occurred.

11) Unable to Substantiate: Defined as non sufficient evidence to prove or disprove the allegation of abuse or complaint.

PROCEDURE:

1) The CRSA QM coordinator is responsible for facilitating the investigation, resolution, intervention, reporting, closure, evaluation, analysis, and trending of quality of care concerns received within the CRS system and reporting to the Executive Session of the CRSA Quality Management Committee (QMC).

2) The CRSA QM coordinator documents each concern raised, when and from whom it was received, and the projected time frame for resolution within the Quality of Care (QOC) Database.

   a) The CRSA QM coordinator will determine whether the concern is to be resolved through:
      i) The quality management program; or
      ii) Grievance and appeals process, process for making initial determinations on coverage and payment issues, or process for resolution of disputed initial determinations. The CRSA QM Division collaborates with the CRSA Members Services to manage the non-quality of care concerns and complaints, determination of coverage, and disputed determinations (See Policy GS 1.1).

   b) When the CRSA QM coordinator receives the concern directly, an acknowledgement letter of the concern explaining to the member or provider the process to be followed in resolving his or her concern will be sent within 5 business days.
      i) If the concern is received by the regional contractor and is a Level 2 or higher, the QM coordinator will enter the concern into the QOC Database and assure an acknowledgement letter is sent and monitor the concern through closure.
      ii) Level 1 quality of care concerns received by the regional contractor will be monitored and acted upon by the regional contractor. CRSA will review a sample of Level 1 quality of care concerns during the regional contractor's annual administrative review to ensure compliance to the RCPPM standards.
      iii) The regional contractor is responsible to send a log of quality of care concerns and non-quality of care concerns/ grievances by the 15th of each month to CRSA. The CRSA QM coordinator will review the logs to validate assignment of the appropriate level and the action(s) taken.

   c) The CRSA QM coordinator will assist the member or provider as needed to obtain resolution of the concern.

   d) The CRSA QM coordinator will, as necessary, inform the member or provider of all applicable mechanisms for resolving the concern external to

the CRSA process (e.g., file complaint with AHCCCS or applicable regulatory agency).

e) Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance, including but not limited to:
   i) Corrective action plan(s) or action(s) taken to resolve the concern;
   ii) In-service attendance and notes;
   iii) New policies and/or procedures; and
   iv) Follow-up with the member that includes, but is not limited to:
      (1) Assistance as needed to ensure that the immediate health care needs are met; and
      (2) Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns.

f) Document the level of substantiation:
   i) Substantiated;
   ii) Unsubstantiated; or
   iii) Unable to Substantiate.

g) An Assessment of the level of severity of the quality of care concern will be made using the following levels:
   i) Level 0 – Track only: No risk of being a quality of care concern, risk of harm, permanent damage, increased cost of care, lengthened stay, permanent damage, or potential media event. Concerns may be related to physical elements of the clinic and discourtesy.
   ii) Level 1 – Concern that MAY impact the member if not resolved: Potential unsafe home environment, non-compliance with appointment scheduling or wait time requirements, or need for information or referral to resolve a concern.
   iii) Level 2 – Concern that WILL impact the member if not resolved: Including slow, or non-responsiveness to a request for evaluation, treatment other request, member rights violation, inadequate case management; physician clinic cancellations, or availability/timeliness of transportation for medical appointments.
   iv) Level 3 – Concern that IMMEDIATELY impacts the member and is considered life threatening or dangerous including situations of immediate jeopardy to the member; abuse and neglect, inadequate or inappropriate care of an acute condition, denial of services deemed medically necessary by the member/provider, potential provider misconduct, concerns with, or the potential for, adverse media coverage or the potential for a lawsuit, and concerns referred by the AHCCCS Director's Office.

v) Level 4 – Concern that no longer impacts the member but may have potential to be life threatening or dangerous to other members:
   (1) Unexpected death has resulted, directly or indirectly as a result of care given or omitted, or media coverage assured or lawsuit filed or in process.
   (2) Examples include cases of abuse and neglect; unexpected deaths; and cases from the Governor's Office, State Legislature, or the ADHS Director/Assistant Director's Office regardless of the nature.

h) The CRSA Quality Management coordinator will ensure action is taken when needed by:
   i) Developing an action plan to reduce/eliminate the likelihood of the concern reoccurring;
   ii) Determining, implementing and documenting appropriate interventions;
   iii) Monitoring and documenting the success of the interventions;
   iv) Incorporating interventions into the organization's QM program if successful; or
   v) Assigning new interventions/approaches when necessary.

i) QOC concerns will be evaluated by the CRSA Medical Director and during the Executive Session of the CRSA Quality Management Committee.

j) The CRSA QM coordinator will assure appropriate concerns are referred to the CRSA Peer Review Committee (See QM 1.1 *CRSA Peer Review Process*) when appropriate.

k) The CRSA QM coordinator will ensure appropriate concerns are referred/reported to the appropriate regulatory agency, Child or Adult Protective Services and AHCCCS for further research/review or action.

l) The CRSA QM coordinator will notify the appropriate regulatory/licensing board or agency and AHCCCS when a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of quality of care concerns.

3) CRSA has developed and implemented a QOC Database to document, track and evaluate complaints and allegations received from members and providers, inclusive of quality of care concerns:
   a) The data from this system is analyzed and evaluated to determine any trends related to the quality of care and non-quality of care issues in the service delivery system and the provider network on a quarterly basis and annually. Data is distributed at the Quality Management Committee (QMC) chaired by the Medical Director.

b) Quality tracking and trending information from all closed quality of care concerns within the reporting quarter is submitted to AHCCCS/DHCM/CQM in quarterly reports, and include the following reporting elements:
   i) Types and numbers/percentages of substantiated quality of care concerns;
   ii) Interventions implemented to resolve and prevent similar incidences; and
   iii) Resolution status of "substantiated", "non-substantiated" and "unable to substantiate" quality of care concerns.

c) CRSA submits to AHCCCS/DHCM/CQM all pertinent information regarding an incident of abuse, neglect and unexpected death as soon as CRSA becomes aware of the incident.

4) If at any time CRSA deems that trending a systemic improvement is required to improve processes, the responsible CRS regional contractor is notified in writing of the need for a corrective action plan (CAP) to prevent further occurrences. Corrective action plans from CRS regional contractors must include the following:
   a) A description of the problem which requires improvement;
   b) Improvement action to be taken on both an individual case basis as well as the system along with the responsible Contractor personnel assignment;
   c) Time frames for implementation; and
   d) Monthly evaluation of progress towards goals.

5) The CRSA QM coordinator monitors the CAPs and if the interventions and/or the corrective actions are not improving the process, CRSA may assign new interventions, impose sanctions and/or other activities as identified by the CRSA QMC to the CRS regional contractor until such time as the concern is resolved.

6) Negative trends within quality of care may be considered when evaluating data to determine the annual Performance Improvement Project (See QM 1.2 *Performance Improvement Projects Policy*) and or other performance improvement activity.

7) Closure will occur when the following conditions have been met:
   a) The quality of care process has been conducted and the concern is determined to be unsubstantiated or unable to substantiate by the CRSA Medical Director;
   b) A CAP is initiated and accepted by the Medical Director (verification of implemented actions will occur during the Annual Administrative Review);
   c) The concern is determined to be resolved through the peer review process;
   d) The grieved party is satisfied with the resolution and there is no further immediate jeopardy based upon the quality of care concern which could

impact the health care needs of the member or another member within the delivery system;

e) A concern may be closed if the grieved party is dissatisfied and the Executive Session of the CRSA Quality Management Committee determines the corrective action(s) are sufficient and further corrective action(s) are unjustified; and

f) When applicable, the appropriate regulatory and or licensing entities have been notified and no further action is required or requested.

Approved:	Date:
CRSA Administrator	6/5/07
CRSA Medical Director	6/6/07